FAMILY PHARMACY &
HEALTHY LIVING CENTER
5403 Pinnacle Point Drive
Rogers, AR 72758

APPLICATION FOR CREDIT

RESIDENT'S NAME - _____
FIRST MIDDLE LAST

FACILITY NAME - _____

ADDRESS - _____ APT # _____
STREET

_____
CITY STATE ZIP

SSN - _____ - ____ - _____ DATE OF BIRTH - ____/____/_____

STATEMENT TO BE SENT TO - _____

ADDRESS - _____
STREET

_____
CITY STATE ZIP

PRIMARY CONTACT PHONE - _____ - _____ - _____

PRIMARY EMAIL ADDRESS - _____

SECONDARY CONTACT PHONE - ____ - ____ - _____

Please attach an executed Power of Attorney document to this application.

IMPORTANT

In order to provide timely service to your family member we MUST be able to rely on the prescription authorizations we are given. Therefore, YOU ARE FINACIALLY RESPONSIBLE FOR ANY AND ALL MEDICATIONS ORDERED BY A PHYSICIAN, THE STAFF OF THE FACILITY OR YOUR FAMILY MEMBER FOR THE BENEFIT OF YOUR FAMILY MEMBER! Your signature below indicates that you have read, understood and agree to the importance of this responsibility on the part of the pharmacy.

SIGNATURE _____ DATE - ____/____/_____

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Billing Options: You will be provided an itemized statement every month for services provided. Payment is due upon receipt and will incur a late payment charge if payment in full is not received by the pharmacy no later than the last business day of the month the statement is issued. Payment can be made on the account in one of two ways:

1. We recommend completing the bank draft authorization on the following page. Payment will be drafted from your selected checking account on the 25th day of the month following receipt of your statement, or the next following business day if the 25th is a weekend or holiday.
2. You may provide a credit card to be maintained on file. Immediately after statements are produced, your credit card will be charged for the month's services. You will receive a copy of the credit card receipt along with the statement for your records.

INSURANCE CARD INFORMATION FOR MEDICATION PROCESSING

BIN # - _____

ID # - _____

Rx GROUP # - _____

Rx PCN # - _____

Arkansas Medicaid # - _____ (if applicable)

CREDIT CARD INFORMATION (if you select payment option #2)

Circle Card Type: VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER

Credit Card Number: _____ - _____ - _____ - _____

Expiration Date on Card: ____ / _____ **(MM/YYYY)**

Security Code: _____ **(see back of card, last 3 digits)**

House Numbers: _____ **(where credit card billing statement is mailed to)**

Zip Code: _____ **(zip code of billing statement)**

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AUTHORIZATION AGREEMENT FOR DIRECT PAYMENTS (ACH DEBITS)

I (we) hereby authorize Debbie's Family Pharmacy & Healthy Living Center, hereinafter called COMPANY, to initiate debit entries and to initiate, if necessary, credit entries and adjustments for any debit entries in error to my (our) Checking Account indicated below at the depository financial institution named below hereafter called DEPOSITORY, to reimburse COMPANY for medications and related services provided to us, and to debit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.

DEPOSITORY NAME _____ **BRANCH** _____

ADDRESS _____ **CITY** _____ **STATE** ____ **ZIP** _____

ROUTING NUMBER _____ **ACCOUNT NO.** _____
(Please attach a voided check to verify these numbers)

This authorization is to remain in full force and effect until COMPANY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

NAME (S) _____ **SSN** _____ - _____ - _____
(Please Print on Line Above)

SIGNATURE _____ **DATE** ____/____/_____

ADDRESS _____ **CITY** _____ **STATE** ____ **ZIP** _____

TELEPHONE (_____) _____ - _____